Governor's Senior Prescription Drug

Task Force Report

August 30, 2001

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APPOINTMENT OF THE GOVERNOR'S SENIOR PRESCRIPTION DRUG TASK FORCE

In July, 2001, Governor Holden commissioned a 15 member bipartisan Task Force and charged them with developing a plan to help Missouri's seniors with the rising cost of prescription drugs. The Task Force: (1) evaluated the obstacles Missourians have in accessing affordable prescription drugs, particularly seniors, as well as other individuals who incur significant costs for prescription drugs; (2) searched for avenues to lower or eliminate those obstacles; and (3) made recommendations to be considered during the special session that is scheduled to begin September 5, 2001. The Governor appointed the following members to the Task Force:

Lt. Governor Joe Maxwell, Chair	Representative Mark Abel
Representative Joan Barry	Representative Pat Naeger
Representative Charles Portwood	Senator Ken Jacob
Senator Jim Mathewson	Senator Marvin Singleton
Senator Sarah Steelman	Ward Bond
Rev. Karla Cooper	Charles Jensen
Dr. Nevada Lee	Ollie Mae Stewart
Sheppard Woolford	

The Task Force solicited testimony at the following five public hearings:

July 19, 2001	Jefferson City, Missouri
July 24, 2001	St. Louis, Missouri
August 7, 2001	Joplin, Missouri
August 16, 2001	Kansas City, Missouri
August 28, 2001	Columbia, Missouri

On August 31, 2001 at 9am there was a roll call vote on the adoption of the draft report. It was adopted by a vote of 13-0. Rep. Barry and Rev. Cooper were absent at that time but signed on to the report later that same day.

EXECUTIVE SUMMARY

A. Recommendations

The Task Force heard overwhelming testimony from seniors and health care professionals on the increasing difficulty seniors[1] face paying for their prescription drugs. Many seniors testified they are routinely forced to choose between paying for food or prescription drugs.

The idea that such a choice should even occur at this point in their lives is unconscionable. It is unacceptable for any senior to have to make the decision between buying food and buying medicine. One Division of Aging caseworker testified that in addition to sacrificing food, many seniors skip dosages of their medications in attempts to ration their medications, or turn off air conditioners or heaters, whichever the season may be, to reduce their monthly costs to afford their medications. Several senior citizens testified they have watched their lifetime savings depleted in only a few short years as a result of the exorbitant costs of pharmaceuticals they so desperately need.

The members believe that although the rising cost of drugs is truly an issue that will need to be addressed by the federal government, it is imperative the state provide relief immediately to the most needy seniors in the state. The Task Force heard testimony that although the $200 pharmacy tax credit was well intentioned, this tax credit is not meeting the needs of seniors. In addition, the tax credit program was initially estimated to cost $20 million. The cost is now nearing $90 million. Many seniors indicated the tax credit was too little, too late and not available to use at the time of the purchase of drugs. The Task Force recommends the $200 pharmacy tax credit be repealed and replaced with a senior pharmacy assistance program that shall begin enrollment by July 1, 2002. However, to ensure a safety net for seniors, if the senior pharmacy program is not implemented by July 1, 2002, then an alternative tax credit program will be considered by the General Assembly to replace the current tax credit.

Another recommendation is to provide a safety net for the most impoverished and medically needy individuals by increasing the Medicaid income limit to 100 percent of the federal poverty level and increasing resource limits to $1,500 for individuals and $2,500 for couples. According to testimony, Missouri has the lowest Medicaid income and resource limits in the nation. The resource limit has not been changed since 1972. These changes would provide a comprehensive healthcare benefit, including

pharmaceutical coverage, to some of the most vulnerable individuals in the state. The costs of these healthcare benefits will be shared by the federal and state governments, with the federal government paying approximately sixty percent of the cost.

The Task Force recommends the program established should not exceed 200 percent of the federal poverty level. It should exclude individuals currently receiving Medicaid and individuals with adequate third party insurance (those plans with an actuarial value that is greater than or equal to coverage provided by senior pharmacy program benefit). This program should incorporate a 6-month crowd out period and a minimum residency requirement to be eligible for the program.

The Task Force had four guiding principles for establishing a meaningful pharmacy assistance program for the most needy seniors in Missouri:

- Create a pharmacy benefit program with comprehensive drug coverage;
- Provide enrollees with responsible access to prescription drugs;
- Ensure the plan is affordable for recipients yet fiscally responsible for the state; and
- Make all stakeholders share in the cost of the program.

An important component of the plan should be that it is subject to appropriations without compromising the core advantages of the plan.

B. Plan Design and Management

The Task Force recommended the following provisions as part of the pharmacy benefit design:

- Co-insurance according to income level and no cap on recipient co-insurance amount. Recommend a cap on state expenditures up to but not to exceed $5,000 per recipient.
- Enrollment fee of $25 per individual for first income tier (up to $12,000 for an individual and $17,000 for a couple) and $35 per individual for the second income tier ($12,001 to $17,000 for an individual and $17,001 to $23,000 for a couple).
- Deductible of $250 for first income tier and $500 for second income tier. Further, the administering authority should recommend changing the deductible amount as one of the cost control measures for the program. **Comment:** The task force discussed various options to be recommended including deductibles, altering the co-insurance to make the plan more catastrophic in nature or, expanding co-insurance to allow for higher income seniors in the program.

- Establish an open enrollment period and require that all recipients re-enroll every year. In addition, there should be a provision that allows seniors to enroll within 30 days of qualifying events for income changes and age. The benefit year for the program should be July 1 through June 30.
- Income levels should be specifically stated in legislation rather than a percentage of the federal poverty level since this will be simpler for participants. First tier of income for program: up to $12,000 for an individual and $17,000 for a couple. Second tier of income for program: $12,001 to $17,000 for an individual and $17,001 to $23,000 for a couple. There should be a "means test"; e.g., enrollees should attach a copy of last year's income tax statement to their enrollment application for this program to demonstrate they meet the income requirements.
- Responsible access to prescription drugs through a balanced cost share. Enrollees should pay a percentage of the pharmacy cost rather than flat co-pay and the recommended percentage is 40 percent of the drug cost. Encourage the use of generic prescriptions through a mandatory generic program that would require the enrollee to pay in addition to the coinsurance amount the difference between the brand name drug and generic drug.
- Recommend legislation to require minimum manufacturer rebates of 15 percent for brand name drugs and 11 percent for generic drugs for pharmacy manufacturers who choose to have their drugs on the optional preferred drug list.
- Recommend paying pharmacies average wholesale price (AWP) minus 10.43 percent for brand name drugs and AWP minus 20 percent for generic drugs for ingredient reimbursement and a $4.09 dispensing fee.
- The Department of Health and Senior Services to administer the program and contract out with a third party to administer the senior pharmacy program.
- Incorporate various utilization management initiatives included in the Pharmacy Enhancement Program (PEP) in the Division of Medical Services in this senior pharmacy program.
- Provide a medical clearinghouse to educate seniors on pharmacy programs available to them in conjunction with other resources available.

C. Pharmacy Plan Oversight

The Task Force recommends the creation of a Commission to be involved in, and focused on, the difficult decisions associated with a comprehensive pharmaceutical benefit plan. The overall purpose of the Commission will be to provide proactive operational and financial oversight in an effort to determine how well the program is operating and whether changes may be necessary to remain within the program's budgeted appropriation. The Commission should have sole responsibility for approving changes to co-insurance, deductibles, enrollment fees, and drug exclusions in relation to pharmacy benefit trends and to make future recommendations on plan design. The Department of Health and Senior Services should oversee the program and contract out with a third party to administer the senior pharmacy program. In the event inadequate funding is available for the program, the administering authority could consider funding first tier income eligibles only, in addition to implementing other cost control measures.

D. Phase Two Recommendations

The Task Force further recommends the Department of Social Services, Division of Medical Services implement cost containment initiatives provided by Don Muse in his presentation for the Medicaid program at the Joplin hearing.

In the future, the General Assembly should look at expanding the income level of the senior pharmacy assistance program if the monies, including federal funds, should become available. They should also examine the possibility of increasing provider reimbursement in the Medicaid program to the usual and customary amounts and identify the costs associated with this recommendation. The General Assembly should also explore innovative ways to increase reimbursement to health care providers in rural areas of the state. Finally, the General Assembly should investigate developing a buy-in program for those seniors above the current income eligibility, at an actuarially sound level and consider developing a disease control model similar to the Illinois model.

E. Summary

It is becoming increasingly difficult and expensive for seniors, many of whom live on fixed incomes, to meet their prescription drug expenses. In many instances, seniors' incomes are too low to meet their basic needs and purchase prescription drug coverage plans. As prescription drugs play an ever-increasing role in overall medical care, affordable drugs coupled with management of their appropriate

use will grow in importance. Therefore, it is critical our society demonstrate an increasing level of commitment to assist seniors in meeting their prescription drug needs through a comprehensive, affordable, and fiscally responsible prescription drug program.

On Wednesday, August 29, 11:25 a.m. the Prescription Drug Task Force adopted, with one dissenting vote, recommendations made by the Task Force that will be incorporated in the final report. The final vote shall be Friday, August 31, at 9:00 a.m. Dissenters shall be given the opportunity to attach their opinions to the report.

See Appendix A for the summary of all Task Force recommendations and Appendix B for adopted senior pharmacy assistance program plan design and its estimated cost.

[1] For the purpose of this report a senior will be defined as a person 65 years of age or older.

Prescription Drug Task Force Recommendations
Addendum by Rep. Charles Portwood

Osteoporosis is a major public health concern in the U.S. and contributes to more than 1.5 million fractures and costs this country almost $14 billion each year. Last year the National Institute for Health noted that simply increasing calcium in the diets of school aged children by 350mg per day could potentially eliminating the long term cost associated with treating osteoporosis in our seniors. Recognizing the cost associated with treating this debilitating disease is far greater than the cost related to prevention, I move that the Task Force include the Missouri Calcium Initiative in the senior prescription drug legislation. Specific language would include the following simple principles:

1) Increase Education about the epidemic of Calcium deficient diets in Missouri and the diseases associated with decreased calcium intake.
2) Encourage Missourians to increase dairy consumption.
3) Give Preference in government food purchasing programs to Calcium-Fortified over Non-Fortified foods provided the costs of fortified foods are equal or less than non-fortified.

Signed by Dr. Charles Portwood

August 31,2001

ADDENDUM TO THE REPORT OF THE GOVERNOR'S SENIOR PRESCRIPTION DRUG TASK FORCE

Recognizing that in all five of the public hearings conducted for this task force there was an overwhelming plea from Missouri citizens to modify or end the Missouri Medicaid Spend Down Program and recognizing that task force Recommendations #2 and #3 address, but do not fully satisfy that need, I submit the following addition:

- A committee or task force should be organized to find alternative and more productive ways to accommodate Missouri citizens in need of medical assistance who exceed the current and proposed Medicaid income and/or resource limits.
- Such recommendations should be presented to the General Assembly during the coming legislative year.
- Such recommendations should take into consideration the high administrative cost and the patients' mental burden of quarterly re-certification for Medicaid benefits, with the thought of extending the re-certification period if some form of spend down is maintained. This would be especially important for those Missouri residents suffering from chronic diseases.

Nevada A. Lee, M.D.

Addendum to the Governor's Senior Prescription Drug Task Force

Senator Marvin A. Singleton, M.D.
Chairman, Public Health and Welfare Committee
Member, Governor's Senior Prescription Drug Task Force
August 30, 2001

There is widespread agreement that the State of Missouri's current prescription drug tax credit program has been a failure. The program costs the state too much and offers too little in return to the elderly who truly need a helping hand when prescription drug costs become too much of a burden on a senior's fixed income. Most of the recommendations which are a part of the final report submitted by the Governor's Senior Prescription Drug Task Force make great strides towards addressing the needs of Missouri's elderly population and I would like to congratulate everyone who has participated in this process. We must continue working towards cost effective solutions that provide significant benefits to our senior population while minimizing the risk to the state during times of slow economic growth and increasing numbers of elderly people.

There are some specific recommendations included in the task force report with which I disagree. The most glaring weakness of the Task Force report is the lack of a safety net protecting Missouri's seniors. The report states that if the newly created senior pharmacy program is not implemented by July 1, 2002 then an alternative tax credit program will be created by the General Assembly. Any number of factors could result in problems serious enough to stop or at least delay implementation of the proposed senior pharmacy program. Under the present recommendations issued by the Task Force, without a new program up and running by July 1, 2002, the existing tax credit program would be eliminated totally and seniors would have no where to turn. It is critical that we provide a safety net or fallback position from

the very beginning just in case this newly created senior pharmacy plan is not operational as stated. Therefore, I would prefer to see a safety net included with any legislation passed by the General Assembly during the Special Session. This safety net would be composed of a reduced tax credit redefined by a means test and its inclusion in the legislation would ease any concerns seniors might have that they could be left without a fully operational program this time next year. We cannot put ourselves in the same position next summer of not having a pharmaceutical plan for low-income elderly people.

While many of the recommendations included in the Task Force report are advantageous and laudable, I implore everyone to continue working in the process to identify problems and find solutions. Expert after expert has come forward to alert us that this problem will continue to grow. In anticipation, the State of Missouri should consider many of the Phase I recommendations now and in the future, so that the state can continue to function and provide assistance to the neediest and the elderly. Unfortunately, some of the provisions contained in the Task Force recommendations would take an existing $82 million program and replace it with an estimated $82 million program, the cost of which is unknown exactly. This leaves the distinct possibility that Missouri taxpayers will be saddled with a program that is much more costly than originally estimated. It is not to say that the effort to provide assistance to the elderly is not commendable and it's purpose is extremely important. The methods, however, until fully documented and verified, are suspect.

Unfortunately, the short time frame between the conclusion of the task force activities that were finished on August 29, 2001 combined with the fact that final recommendations were not obtained until later that same day, did not provide the committee with the time necessary to allow for a full analysis of cost and projected figures from independent experts. A draft of the

report was not distributed until the afternoon of August 30, 2001, before a vote was to occur the following morning.

There are still many questions and much doubt remains about what assumptions the actuarials used to arrive at the estimated costs of the new program and additional time is needed in order to fully assess the data and the assumptions that were made. Representatives from William M. Mercer & Co. were selected by Lieutenant Governor Joe Maxwell to serve as the actuaries used to provide economic analysis for the task force. This same company was used by the Department of Social Services to provide analysis of the Medicaid program during the last legislative session. It should be pointed out that the Missouri House of Representatives overwhelmingly rejected the Mercer group's figures and savings that were projected, and by majority vote, turned down the recommendations of the Mercer group.

Several experts have agreed that the figures that were given to the task force are subject to interpretation and therefore specific cost analysis could vary widely depending upon what assumptions were made. The lack of time to fully study the working papers and the methods of arriving at their assumptions for who is eligible, number of participants and total plan cost leaves the costs estimates used by the task force open to doubt.

It is entirely possible that the true cost of the new program recommended by the task force could surpass $80 million in the first year. Estimates used by the task force could become even more skewed with the possibility of growth between $30 and $100 million each year thereafter. It behooves us all to make sure that the figures are accurate. Unfortunately, projected costs for the new program were not forecast beyond 2 years when under normal circumstances, fiscal notes for legislation are projected at a minimum over a 3-year period and preferably over 5 years, as in the case of the basketball arena in Columbia, Missouri. The cost estimates of this

proposed plan do not take into account the tremendous influx of the "baby boomers," which is anticipated to significantly add many eligible participants in the coming years.

Task force recommendations providing for the expansion of the current Medicaid program should not be enacted into law. By implementing recommendations #2 and #3, 10,000 eligible individuals would be added to the Medicaid rolls at a cost of around $10 million per year. This cost is not included in the recommendations of the Mercer group nor is it reflected in the state cost of the senior drug program.

We can not in good faith expand the Medicaid rolls when the State of Missouri does not provide adequately for our citizens presently on the Medicaid program. Dental services are a perfect example. Many people are currently driving hundreds of miles to receive their dental care. The General Assembly appropriated $7 million to improve this situation, but unfortunately, it was vetoed. Until such time as we receive adequate compensation for our providers across the State of Missouri and our citizens that are presently qualified, eligible and on Medicaid receive the services that they need including those in the rural areas, an expansion of 10,000 more recipients will do nothing but expand the crisis in the delivery of health care. We should not support this recommendation as part of the senior's prescription drug program considering that approximately 75% of those that would be added to Medicaid are not elderly at all. In fact, they are below the age of 65 years. Only about 25% would be over the age of 65 years.

Additionally, it is suggested that the Division of Medical Services immediately implement cost containment initiatives as provided by outside consultants, Muse & Associates rather than the Task Force recommendation that these initiatives be implemented later as a Phase II recommendation. With a loss of over $30 - $40 million per year due to lack of oversight and

inefficiencies, there is an immediate need to correct the problems identified in the Medicaid payment system.

Most of the recommendations included in the task force report for the Governor's Senior Prescription Drug Task Force merit inclusion in future legislation to address the issue of prescription drugs. However, there are enough doubts about the economic assumptions used to base the cost estimates of the new senior pharmacy program, that I believe it is important to include a safety net provision protecting seniors should these estimates fail to match reality.

Chair's Summary of the Testimony

Submitted by Lieutenant Governor Joe Maxwell, Chair

Governor's Senior Prescription Drug Task Force

August 30, 2001

TABLE OF CONTENTS

I. INTRODUCTION

Like the United States as a whole, Missouri's elderly population is increasing as a proportion of its total population. Data from the 2000 U.S. Census Bureau and National Center for Health Statistics show that 755,379 Missourians, approximately 13.5 percent of all state residents, are over the age of 65, and seniors will reach 20.2 percent of the state's population by 2010 **(Appendix C)**. Seniors over the age of 60 represent 17.6 percent of the state's total population and make up 22-30 percent of the population in several house and senate districts per the new redistricting information **(Appendix D)**. Missouri ranks 13th nationally in the percent of population age 65 and over. In the 1990s the number of Missouri's oldest seniors, those ages 85 and older, increased by over 30 percent.

Missouri's seniors' income and health insurance coverage are important issues in examining access to affordable prescription drugs. Many older Missourians rely on limited fixed incomes, with estimates showing that nearly nine percent of Missourians age 65 and older at or below the federal poverty level **(Appendix E)**. Although most seniors in the United States have health insurance coverage through the federal Medicare program, it does not cover the costs of outpatient drugs and over the counter medications. Written documentation provided to the Task Force suggested that among the 40 million seniors enrolled in the Medicare program, approximately 10 percent are classified as poor and another seven percent as near-poor **(Reference 1)**. According to Missouri Department of Insurance information, through July 1999, Missouri had 734,440 persons 65 and older participating in the Medicare program. Of these, a known 179,205 Missourians, 24.4 percent of elderly Medicare beneficiaries, had full or partial drug coverage. Most of these seniors obtain limited drug coverage through the eight Medicare HMOs available in the state. These plans charge enrollees out-of-pocket premiums, from $500 a year up, and severely limit or have dropped coverage of expensive brand-name drugs **(Reference 2)**. Others obtain insurance through Medigap plans also known as supplement policies. However, many of these supplemental policies restrict access to prescription drug coverage through high premiums (some up to $3,200 per year), moderate to high copayments and deductibles, and annual caps on the total costs of prescriptions. Further, employer-sponsored health plans which typically offer prescription drug benefits are declining as a form of insurance coverage for seniors; while 35 percent of seniors had such coverage in 1995, this proportion had fallen to approximately 28 percent of seniors in 2001. Of the employer plans that offered retiree medical insurance 80 percent also cover prescriptions **(Reference 1)**. While the

Medicaid program does provide comprehensive prescription drug benefits at no or minimal cost, nationwide nearly 60 percent of Medicare enrollees with incomes below the federal poverty level were not covered by Medicaid in 1997 **(Reference 1).** Although nationwide elderly persons represent only about 14 percent of the total population, they account for approximately 43 percent of the total drug expenditures **(Reference 3)**. In the Missouri Medicaid program, seniors and persons with disabilities represent approximately 22 percent of the total Medicaid population, yet 85 percent of the total pharmacy expenditures in the program are spent for these two populations. Seniors make up 9.4 percent of the total Medicaid population and consume 30 percent of the total Medicaid dollars for their total health care expenditures **(Reference 4).**

The increasing costs of prescription medications create particular hardships for senior citizens, many of whom rely on fixed incomes. The Task Force received written and verbal testimony documenting the increasing costs of prescription medications. The National Conference of State Legislatures reports the annual rate of increase in prescription drug expenditures has grown from 10.6 percent in 1995 to 17.4 percent in 1999. This rate of increase compares to an estimated increase of 5.3 percent in 1999 for all health spending and is four times the rate of growth for hospital expenditures **(Reference 1).** State officials report the Medicaid budget is experiencing cost increases for prescription drugs of about 15 percent annually and pharmaceuticals are the fastest growing component in the Medicaid budget **(Reference 4)**. Another source reports that drug expenditures in the United States more than tripled in the last decade and are expected to more than double between 2000 and 2010, from an estimated $117 billion to $366 billion, according to the Centers for Medicare & Medicaid Services (CMS) **(Reference 3).** Medicare enrollees in 1999 spent an average of 19 percent of their income on health care costs, of which 17 percent was spent for prescription drugs (an average of $410 per enrollee per year). Approximately 86 percent of seniors use at least one prescription drug in 1995 and the average senior fills 18 prescription medications year. " While the average total cost is $1343, the average person with coronary artery disease, high cholesterol, and Type 2 diabetes spends over $3000 a year" **(Reference 5)**.

In summary, many seniors have limited or no access to prescription drug coverage through health insurance policies; as a result, these elderly individuals typically face out-of-pocket expenses that are difficult to afford. Many low-income elderly, especially those with no or limited prescription drug benefits must make difficult choices about where to spend limited financial resources. Their decisions may result

in not filling the prescriptions needed to treat acute and chronic health conditions, not taking their medications as prescribed, or being forced to choose between paying for food or their medications **(References 6 and 7)**. One physician testified,

> I've seen patients before they get into the nursing home and sometimes this is the reason that they end up there, they will skimp on other essentials in order to get the medications paid for. They've been told so many times you must take your medicine as prescribed that they will do whatever possible to pay for the medicine as prescribed that means they'll eat only one meal a day. That means that they won't turn their air conditioning on in the summer because that's more expensive and they'd rather pay for their medications. So because of that, then they get dehydrated or heat stroke or end up in the hospital for other reasons **(Reference 8)**.

One Division of Aging caseworker testified that in addition to sacrificing food, many seniors skip dosages of their medications in attempts to ration their medications, or turn off air conditioner or heaters, whichever the season may be, to reduce their monthly costs to afford their medications **(Reference 9)**.

This situation is of interest from both a humanitarian and public policy perspective certainly not taking needed medications can result in higher societal health-related costs. Through the proper use of prescribed medications, hospitalizations, costly medical procedures, and nursing home institutionalizations might be avoided or at least postponed.

Governor Holden made prescription drug relief for seniors one of his highest priorities. In Fiscal Year 2002, Governor Holden established a trust fund with tobacco settlement money and recommended funding a prescription drug program for seniors from this trust fund. The General Assembly approved $63.2 million for a senior prescription drug plan; unfortunately, they were unable to pass legislation to use this funding. The Task Force heard overwhelming testimony that seniors need assistance immediately with affording prescription drugs and that they can no longer wait for the federal government to address this critical need. Prescription drug costs continue to rise, while the limited income of our seniors remains the same.

II. WHY DRUG EXPENDITURES ARE INCREASING

Information concerning the reasons for the increased costs of drugs and increased expenditures on drugs was presented to the Task Force. Two major factors contributing to increased costs of pharmaceuticals are: 1) increased utilization of drugs by seniors (number of drugs per user and increase in length of days prescription is prescribed) and 2) increased cost for drugs **(References 4, 10, and 11)**. Over the past few years, pharmacy costs have steadily increased ranging from 15 to 20 percent. Approximately half of this increase is due to utilization and the other half due to cost. The cost increase

can be broken down further into inflation (4 to 5 percent) and the cost of new pharmaceuticals, that are replacing less expensive therapies **(Reference 12).** New and sometimes more effective prescription medicines are the chief cause, especially treatments for chronic conditions (such as hypertension) that affect many senior citizens. Many seniors switch to newer, more expensive medications from older, less costly drugs. The newer medications often offer distinct advantages. In some cases patient demand is stimulated by consumer directed advertising of a particular medication. A physician as well as seniors testified that patients are increasingly requesting particular name brand drugs they have seen advertised **(References 5, 11, 13, and 14)**; and the 25 most heavily promoted drugs accounted for 40 percent of the increase in retail drug spending in 1999 **(Reference 5)**.

Another reason presented to the Task Force for increasing drug expenditures is the rising cost of drugs. There was testimony that the increase in drug costs is associated with the long patent life for drugs and that the patents and patent extensions often insulate drug companies from competition from less costly generic drugs and that some drug companies are purchasing generic drug manufacturers to control the market on their drugs **(Reference 14)**. Several seniors testified concerning the significant difference in cost of drugs in Missouri versus other countries like Mexico and Canada. Some drug makers contend they are forced to discount drug prices in international markets where government price controls are common. This means that "there's cost shifting, where American consumers pay more because people overseas pay less". Similarly, "...the pharmaceutical industry has to earn most of its profits in the United States, the only major country where drug prices remain unrestricted" **(Reference 15)**. Higher drug prices may also be evidenced by drug industry profits that

> ...surpass almost every other major economic sector. In its annual ranking of America's most profitable industries; Fortune magazine placed the pharmaceutical industry at the top in all three categories - return on revenues, return on assets and return on shareholders' equity – for 1999 **(Reference 16).**

According to one senior, the Public Citizen's recent report's key findings indicate that drug companies are not spending what they contend they are for research and development of prescriptions. In fact, "the actual after tax outlay which drug companies really spend on R&D for each new drug including failures is $110 million. . .this is a marked contrast with the $500 million that PhARMA frequently puts out" **(Reference 14)**.

III. PRESCRIPTION DRUG ASSISTANCE PROGRAMS IN OTHER STATES

More than half the states have pharmaceutical assistance programs in operation, and many other states are developing programs. Some states have expanded their Medicaid programs to provide coverage for additional groups, including low-income seniors; some states are making available Medicaid-type rebates or discount rates for retail drug prices for certain groups, including the elderly; and some states have instituted state price controls on certain types of drug purchases. The majority of the state programs provide direct subsides to the participants. Direct subsidy programs pay the difference between a copayment paid by the beneficiary and the cost of the prescription. Most programs include an annual deductible, or an annual or monthly enrollment fee. These programs use age, income level, and other criteria to target benefits to a specific population **(Reference 17).** The pharmaceutical assistance programs enacted by the following states represent the variety of prescription drug assistance states are providing to their senior residents:

California - The state program prohibits pharmacies participating in the state Medicaid program from charging Medicare beneficiaries more for their prescription drugs than the Medicaid reimbursement rate plus a processing fee.

Maine - The State established the Maine Rx Program, under which the state functions as a pharmacy benefit manager. The state is authorized to decrease prescription drug prices through purchasing alliances and other regional strategies. The state prohibits profiteering among manufacturers, distributors and labelers of prescription drugs. The state also authorized maximum retail prices effective July 1, 2003, for certain drugs.

Massachusetts - A state bulk-purchasing program was created to include Senior Pharmacy Assistance enrollees, Medicare and Medicaid recipients, state workers, and underinsured and uninsured persons. A Pharmacy Outreach Program is established to assist residents in obtaining free or low-cost medications from pharmaceutical companies. The state revised its Catastrophic Prescription Drug Insurance Program for all elders aged 65 years and older, with sliding scale deductibles and copayments, but no maximum income limits. Persons with incomes of up to 188 percent of the federal poverty level have no premiums or deductibles.

Pennsylvania - The state established pharmacy assistance programs for low-income and moderate-income elderly with minimal copayments and deductibles (PACENET assists seniors with higher annual incomes and requires satisfying an annual $500 deductible). Both programs require generic substitution unless such a substitution is not medically prudent.

IV. ISSUES AND RECOMMENDATIONS PRESENTED TO THE TASK FORCE

The Task Force received information about the following issues and recommendations through both written and verbal testimony provided at the five public hearings:

A. Repeal Missouri's $200 Pharmaceutical Tax Credit - In 1999, Senate Bill 14 was passed which authorizes a $200 tax credit for unreimbursable pharmaceutical expenses for Missouri residents age 65 years or older. There is a limit of $15,000 in individual adjusted gross income in order to qualify for the full tax credit; however, individuals with incomes of up to $25,000 may receive a partial tax credit. The tax credit is refundable (any amount of the credit above the resident's tax liability is refunded), and is effective from January 1, 1999 through December 31, 2004. Although originally estimated to cost $20 million per year, the tax credit program is estimated to cost $89.3 million in Fiscal Year 2002 **(Reference 18)**. The Task Force heard testimony that this program is seriously flawed and even if fixed provides too little too late to seniors **(References 19 and 20)**. A 73-year-old man testified he has heart problems and is handicapped. In addition, he has a Medicare supplement plan that costs $103 a month. Still he spends over $300 a month on prescription drugs. He stated that while he appreciated the $200 tax credit, "it doesn't even cover one month's medicine" **(Reference 19)**. Several individuals expressed similar thoughts about the tax credit program and their concern about the way the tax credit bill was written, interpreted, and administered by the Department of Revenue. Some expressed their concern about couples where one individual earned $80,000 a year and the other spouse earned anywhere from $10,000 to $25,000 yet, the lower earning spouse still qualified for the pharmaceutical tax credit **(References 20 and 21)**. The sponsor of Senate Bill 14, Senator Mathewson, testified there were many flaws with the bill and that it was never the intention of the legislature to cover these couples. He urged the committee to recommend repealing the tax credit and redirecting those dollars to fund a meaningful prescription drug program for the most needy seniors in the state **(Reference 21)**. Others testified that this minimal amount of money did not provide any assistance to some seniors who really needed help (e.g. those individuals who are so poor that they do not have to file taxes), and for those who received the credit, it did not

provide very much relief. In addition, the credit does not provide seniors with assistance throughout the year as they are struggling to pay for their medications. Finally, along with these problems, the tax credit was estimated to cost $20 million and is now nearing $90 million a year **(Reference 26)**. The Task Force ultimately recommended repealing the $200 pharmaceutical tax credit and replacing it with a senior pharmacy assistance program that shall have begun enrollment by July 1, 2002. If the pharmacy assistance program is not implemented by July 1, 2002, then an alternative tax credit program should be legislated.

B. Expand Medicaid income and resource limits to allow additional senior citizens and persons with disabilities to qualify for the program's comprehensive health insurance benefits, including prescription drug coverage - Much of the testimony heard by the Task Force surrounded the Medicaid Spenddown Program. Spenddown allows persons who are age 65 years or older, blind or disabled, with incomes above the medical assistance limit, to qualify for Medicaid. The income limit is the Supplemental Security Income (SSI) monthly maximum, currently set at $531 per individual and $796 per couple. Persons with incomes above the SSI limit must "spenddown" to that level; that is, they must present documentation that they have incurred allowable medical expenses totaling or exceeding the amount that their income exceeds the SSI limit before they become eligible for Medicaid benefits. Once they are determined eligible for Medicaid, comprehensive prescription drug coverage is available. Spenddown eligibility is determined for a three-month period on a quarterly basis and must be re-established on a quarterly basis. A number of persons testified that the low SSI income limit on which spenddown eligibility is based presents a hardship for those with limited incomes, since it requires they incur high out-of-pocket expenses before receiving any assistance.

There are certain earned income exemptions including a $20 personal income exemption, deductions for other health insurance premiums paid and for SSI payments. In addition to meeting income guidelines, an individual must have resources (assets) below $999 for an individual and $2,000 for a couple. There are exemptions to the resource limit including homestead, value of a vehicle, personal property, property attached to the home site, and irrevocable prepaid burials. Among those things that do count as resources are cash in the bank, savings, cash surrender value of life insurance, and liquid assets **(References 27 and 28)**. According to written testimony provided to the committee, "these are the

neediest of the needy (by definition, over 65, permanently and totally disabled, or blind) and they are definitely low income" **(Reference 29)**.

> Missouri has the lowest Medicaid resource limit of all 50 states. In addition, the income limit of $530 for a single person is well below the poverty level and below the income requirements for other programs. Our current low Medicaid eligibility causes people to postpone or avoid medications as well as home and community services that could help them now. These treatments could stabilize or improve their conditions. Instead, the condition worsens and turns into something that requires expensive surgery or hospitalization. Not only do we have a financial cost but also a human cost in terms of pain and loss of quality life **(Reference 30).**

In addition, there was discussion concerning the abuses in and manipulation of the spenddown program that result primarily because qualifying for the spenddown program is based on incurring medical expenses rather than actually paying for medical expenses. Some individuals indicated they believed changing the Medicaid eligibility requirements for the spenddown program might actually decrease health care costs because individuals will not go to emergency rooms for non-urgent health care problems or request unneeded medications to reach their spenddown amount early in the quarter.

The Task Force heard overwhelming testimony from many seniors and persons with disabilities concerning this issue and recommends the state increase the Medicaid income limit to 100 percent of the federal poverty level and the resource limit to $1,500 for an individual and $2,500 for couples. These Medicaid eligibility changes would provide a comprehensive healthcare benefit, including pharmaceutical coverage to some of the most vulnerable individuals in the state. The costs of these healthcare benefits can be shared by the federal and state governments, with the federal government paying about sixty percent of the cost.

C. Establish a separate state prescription assistance program for the most needy seniors

The Task Force had four guiding principles for establishing a meaningful pharmacy assistance program for the most needy seniors in Missouri:

- create a pharmacy benefit program with comprehensive drug coverage;
- provide enrollees with responsible access to prescription drugs;
- ensure the plan is affordable for recipients yet fiscally responsible for the state; and
- make all stakeholders share in the cost of the program.

An important component of the plan should be that it is subject to appropriations without compromising the core advantages of the plan.

1. Eligibility Requirements

Age: There was testimony that most state senior programs require enrollees to be at least 65 years of age and some require participants to be 67 years of age **(References 31 and 32).**

Exclusions: Recommendations were made to exclude individuals who are receiving Medicaid. Many seniors expressed their reluctance to be forced into the Medicaid program rather than getting some assistance exclusively with their prescription drug expenses. The Task Force recommended only excluding those individuals actually receiving Medicaid versus eligible for Medicaid from the senior assistance program. In addition, it was recommended to exclude those individuals with third party insurance that is greater than or equal to pharmacy benefit coverage in the state program. In addition, members discussed having a six-month crowd out provision to dissuade individuals from dropping private coverage to join a state program.

Income: One expert on senior drug programs provided the Task Force with a comparative analysis of many of the state senior pharmacy assistance programs. The analysis demonstrated most states decide what federal poverty level they could afford to go up to with the plan. The income levels range from 100 percent to 300 percent of the federal poverty in the various states **(Reference 33).** The Task Force recommended the income levels be specifically stated in legislation rather than a percentage of the federal poverty level since this will be simpler for participants. There was a lot of discussion over what income levels to cover in this program; however, ultimately the Task Force opted to select the following income levels and to consider this recommendation a first phase to assist seniors with the high cost of prescription drugs. In the event that more money would become available, then the state could expand the coverage of the program to seniors earning more income. The Task Force recommended the following income levels for eligibility in the program: up to $12,000 for an individual and $17,000 for a couple for the first tier of eligibility and going from $12,001 to $17,000 for an individual and $17,001 to $23,000 for a couple for a the second tier of eligibility.

Residency: The Task Force heard testimony that states' rules vary considerably concerning the period of time that a person resides in the state in order to qualify for the program. For example, Indiana requires that a person must be a resident of the state for 90 days prior to becoming eligible for the

program. Nevada's new program requires that you reside in the state for 12 continuous months previous to enrolling in the program **(Reference 33).** The Task Force recommended requiring individuals to reside within the state for 12 continuous months prior to becoming eligible for the program.

Relationship between state program and any future federal program: The Task Force expressed interest in ensuring that any pharmacy assistance program established by the state work in conjunction with any federal program that may be established in the future and that this program be the payer of last resort. There was concern expressed about the federal government requiring a maintenance of effort for states who have already established assistance programs.

2. Cost Sharing Provisions

Several witnesses testified concerning the various cost-sharing measures used by other state pharmacy assistance programs, state employee health plans, private health plans, and self-insured employers. The cost-sharing measures include annual enrollment fees, annual deductibles, copayments (flat and tiered) or coinsurance (recipient pays a percentage of actual drug costs) and preferred drug lists **(References 31-35).** Many states have varying copayments and deductibles based on the individuals' income level **(Reference 33).**

Coinsurance: A pharmacy consultant for the Missouri Department of Transportation (MoDOT) testified they recently changed from a tiered copayment method on prescriptions to a percentage of drug cost and that this change has dramatically lowered the total pharmaceutical expenditures for MoDOT. He explained when a pharmacy benefit program has a fixed-copay; consumers do not know the total cost of the drug. The consultant encouraged the Task Force to recommend in the plan design that consumers pay a percentage of the drug cost (i.e. coinsurance) so participants can be better purchasers of prescription drugs **(Reference 34).** The Task Force members strongly agreed with this concept and ultimately recommended the enrollee pay 40 percent of a drug's cost. To contain the costs of the program, the members opted to not have a maximum annual cap on the amount of coinsurance the enrollee would pay for their medications.

Deductible: One speaker recommended that a deductible must be met prior to the state paying and it should be done electronically through the point of service system in the Division of Medical Services so that the state is not forced to act as a collection agency. He noted it is possible to implement an edit to the point of service system that is currently used by the Division of Medical Services in the state of Missouri

(Reference 33). The Task Force recommended a tiered deductible of $250 for the first tier eligibles and $500 for the second tier eligibles. The members discussed the concept of having a monthly rolling deductible rather than an annual deductible but opted to have an annual deductible that must be met before the state would be responsible for the bills.

Enrollment Fee: Concerning enrollment fees, one speaker testified that enrollment fees are almost universal and are usually set at $25 per individual. Some states waive the fee based on income levels. For example, Illinois has a $5 fee and a $25 fee, based on income; however, the recipient can have the $5 fee waived **(Reference 33).** Furthermore, some states such as California have prescription fees of 15 cents per prescription that are paid to pharmacies by recipients **(Reference 33).** The Task Force recommended the establishment of a $25 annual enrollment fee for the first income tier eligibles and $35 annual enrollment for the second income tier eligibles and this enrollment fee should not be counted toward the enrollee's annual deductible.

Annual Benefit: According to testimony presented to the Task Force, several states have a cap on the amount of money the state will pay for each recipient. For instance, Delaware pays for a maximum of $2,500 a year for an enrollee's prescription costs; Florida will pay up to $180 a month; Indiana will pay only $1,000 a year; and Illinois has the recipient pay the first $2,000 and then after that the recipient pays 20 percent of the drug costs **(Reference 33).** The Task Force recommended having a maximum annual cap of $5,000 on the amount the state would pay for each individual. This allows the state to assist seniors to a much greater extent than the current tax credit; however, it also ensures the program is fiscally responsible.

Preferred Drug List / Rebates: According to testimony presented to the Task Force, many states collect rebates in their senior pharmacy assistance programs and the rebates range from 15 to 20 percent of the total pharmacy program costs (state cost plus recipient cost). The states with the most aggressive rebates recovered are basically modeled after the federal rebate program for Medicaid. Manufacturers are required to sign a rebate agreement with the state for the state-only program, to participate in the program, and to pay rebates using the national rebate amounts. If they do not sign an agreement with the state, the state will not pay for their products. A few of the states using this model are Connecticut, Maine, and New York, and Michigan is moving in this direction. Some states have programs that are more moderate in the collection of rebates and are patterned after the federal program, but modify the unit

rebate amount. Typically, it excludes Consumer Price Index Urban (CPIU) factor that is built into the rebate methodology in brand products in the federal program. Again, they require pharmaceutical manufacturers to participate in the program and if they do not sign a contract or an agreement with the state, the state will not pay for their products. States currently using this model include New Jersey, Delaware, and Pennsylvania. The least aggressive rebate programs require manufacturers to sign contracts; however, do not restrict drug coverage to just those that have a rebate provided by the manufacturer. Although these states have a preferred drug list, they do not enforce it. States using this approach had a 0 to 1 percent collection rate versus total expenditures, and include Illinois, North Carolina, and Maryland **(Reference 35).**

3. Open enrollment and benefit period

The Task Force recommends the establishment of an open enrollment period and requires that all recipients re-enroll every year. In addition, there should be a provision that allows seniors to enroll within 30 days of qualifying events for income and age. The benefit year should be July 1 through June 30 to align with Missouri's fiscal year budget.

4. **Pharmacy reimbursement**

There was a lot of discussion concerning the need to ensure that local pharmacies can remain financially solvent with a new pharmacy program. This will allow seniors to continue to receive their prescriptions at their local pharmacies. The task force recommended $4.09 dispensing fees and average wholesale price (AWP) minus 10.43% for brand name drugs and AWP minus 20% for generic drugs for ingredient reimbursement for pharmacies.

5. Cost containment provisions of the plan design

The Task Force recommended incorporating the Division of Medical Service's Pharmacy Enhancement Program (PEP) cost containment initiatives with the exception of the four-brand script limit, mail order service, and pill splitting. The Task Force heard a lot of testimony emphasizing the importance of using generic equivalent drugs as a way to reduce pharmaceutical expenditures. Because generic equivalents for brand name medications typically are one-half the cost of brand drugs, facilitating the use of generics would result in considerable costs savings both to patients and publicly funded prescription benefit programs. The Task Force was urged to encourage and even mandate the use of generic equivalents. Practices that impede the availability of generic equivalents include the ability of drug

companies to litigate for patent exclusivity extensions and delay generic drugs being available. Such extensions afford an additional 30 months of protection from generic competition. Some states like New Jersey and Pennsylvania require the recipient to use generic drugs when available. Otherwise if the recipient and doctor request a brand name drug, then the recipient pays the difference between the brand name drug and the generic drug **(Reference 36).**

Another measure that promotes quality health care and secondarily saves the state money is case management of individuals who use a large number of drugs. One expert testified that the state should run this program through the Division of Medical Services' current point-of-sale system and implement an edit that would require a health care professional to review any individual who receives over a certain number of drugs and decide if it is appropriate utilization. These checks and balances in the system will help ensure the recipient as well as the health care professional know if all the drugs are needed and whether a drug conflicts with the patient's other medications **(Reference 37).**

6. Authorization of administering authority to make future recommendations on plan design

The Task Force recommends the creation of a Prescription Drug Review Commission to be involved in, and focused on, the difficult decisions associated with a comprehensive pharmaceutical benefit plan. The overall purpose of the Commission is to provide proactive operational and financial oversight in an effort to determine how well the program is operating and whether changes may be necessary to remain within the budgeted appropriation of the program. The Commission should have sole responsibility for approving changes to co-insurance, deductibles, enrollment fees, and drug exclusions in relation to the pharmacy benefit trends.

7. The senior pharmacy assistance program established should not exceed 200% of the federal poverty level.

Several members expressed concern about having the program cover those individuals with incomes over 200 percent of the federal poverty level. Most believed the program should begin with targeting the lowest income levels and then possibly expanding the eligibility for the program in future years should additional monies become available. Several members advised that the pharmaceutical manufacturers were willing to provide rebates up to this percentage of poverty; however, were not willing to go above this level and that if the state opted to go above this level, then the rebates could be in jeopardy.

8. The senior pharmacy assistance program should be overseen by the Department of Health and Senior Services, Division of Aging and they should contract out with a third party to administer the senior pharmacy program.

Several members expressed concern about having the program run by the Medicaid agency and ultimately thought that Division of Aging should oversee the program. They felt there would be a negative stigma if this program were housed in the same division as the Medicaid program. However, members were not opposed to the Division of Aging coordinating with the Division of Medical Services (DMS) and utilizing many of the tools and infrastructure that currently exists within the DMS such as the point of service system, various cost control measures incorporated in the Pharmacy Enhancement Program (PEP) in Fiscal Year 2002, rebate collections, and the use of the Drug Utilization Board and Prior Authorization Board to assist in the administration of the senior pharmacy assistance program.

V. OTHER ISSUES AND RECOMMENDATIONS

Several other issues were brought to the Task Force's attention, including:

- Recommend DMS implement cost containment initiatives provided by Don Muse in his presentation for the Medicaid program.
- Create a healthcare clearinghouse and expand outreach on pharmacy assistance programs sponsored by the pharmaceutical manufacturers. Information was provided about the pharmacy assistance programs that some drug manufacturers have in place to assist individuals in obtaining needed medications. While each company has different eligibility requirements and application processes, typically the assistance requires a referral through the patient's physician and some form of documentation of financial need. If a participant is approved, the assistance programs provide the covered medications at no or reduced costs to the patients. PhARMA reported to the Interim Committee on Affordable Prescription Drugs that in 1999, more than 40,000 Missourians received free or reduced price drugs through these pharmaceutical company assistance programs. Several barriers to using these programs were identified, including: (1) not all physicians are aware of the programs so their patients are not able to participate; (2) some physicians refuse to participate largely because of the time demands created by paperwork; (3) only medications without a generic alternative are usually available; and (4) some patients are discouraged from participating in these

programs because of restrictions on the supply of prescriptions (often only one month's supply of a medication is available).

- In the future, general assemblies should look at expanding the income level of the senior pharmacy assistance program if the monies, including federal monies, should become available.
- The General Assembly should further examine increasing provider reimbursement in the Medicaid program to the usual and customary amounts and identify the costs associated with this recommendation.
- The General Assembly should examine innovative ways to increase reimbursement to health care providers in rural areas of the state.
- In the future, the General Assembly should consider developing a buy-in program for those seniors above the current income eligibility, at an actuarially sound level.
- In the future, the General Assembly should consider developing a disease control model similar to the Illinois model.

VI. CONCLUSIONS AND RECOMMENDATIONS OF THE TASK FORCE

The Task Force recognizes that the need for public assistance with the costs of prescription medications for seniors is imperative. Many elderly residents are struggling to afford the medications that add years and quality to their lives. Seniors who do without needed medications or take lower dosages than prescribed because of the costs often face expensive hospitalizations, costly medical procedures, or institutionalization. The Task Force also recognizes there are limited financial resources available for this program and that the state should be fiscally responsible in developing a pharmacy assistance program. Therefore, the members are recommending that there be cost sharing provisions to encourage prudent purchasing by enrollees and the program design incorporate similar cost containment measures, referred to as the Pharmacy Enhancement Program (PEP) as were approved during the budget process this past legislative year for the Medicaid program with the exception of using the four brand script limit, voluntary mail order, or pill splitting initiatives. With these realities in mind, the Governor's Senior Prescription Drug Task Force makes the following recommendations:

- Target any state prescription drug assistance efforts to the neediest of our elderly residents and incrementally phase-in seniors with higher incomes and those with a

demonstrated need for assistance with their prescription medication expenses to any state program that is developed;

- Repeal the existing $200 pharmaceutical tax credit and redirect those funds to establish a meaningful pharmacy assistance program for the neediest seniors. If a pharmacy assistance program is not implemented by July 1, 2002, then an alternative tax credit program should be legislated.

References

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2. Information submitted by Department of Insurance on August 7, 2001.
3. Kaiser Family Foundation. Prescription Drug Trends a Chartbook. July 2000.
4. Kathy Martin, Director of Department of Social Services testimony and information presented to Task Force on July 19 per transcript page 11-13.
5. Written testimony provided by Dr. Steven Zweig, a copy of which may be found in Appendix E.
6. Jeanne Piffel testimony on July 24 per transcript page 35.
7. Dr. Stephanie Van Ulft, testimony on July 24 per transcript page 188.
8. Dr. Kim Carmichael, M.D., testimony on July 24 per transcript page 180.
9. Ms. Alden testimony on August 7 per transcript page 15.
10. George Oestreich testimony on July 24, page 113.
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12. William M. Mercer, Incorporated actuarial data analysis for State of Missouri, August 2001.
13. Dr. Charles Crecelius, President of MO Association of Long Term Care Physicians and Board Member of the American Medical Association, testimony on July 24. (transcript does not include his testimony)
14. Anne Steele, Advocacy Chairperson OWL, testimony on July 24 per transcript page 195.
15. David Noonan, "Why Drugs Cost So Much", Newsweek, September 25, 2000, page 26.
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17. Samantha C. Ventimiglia, testimony on July 19 per transcript page 30.
18. Brian Long testimony on July 24 per transcript page 140.
19. Mr. Penner testimony on August 7 per transcript page 175.
20. Ray Davidson testimony on July 24 per transcript page 30-31.
21. Senator Mathewson statements on August 16 per transcript page 88.
22. Oli Stewart statements on August 16 per transcript page 90.
23. Representative Abel statements on August 16 per transcript page 94.
24. Dr. Lee statements on August 16 per transcript page 95-96.
25. Sen. Mathewson testimony on August 7 per transcript pages 149-154.
26. Brian Long, Deputy Commissioner for Budget and Planning, testimony on July 24 per transcript pages 14-21.
27. Denise Cross, Director of Division of Family Services, testimony on July 19 per transcript pages 15-17.
28. Jim Moody, Lobbyist for Missouri Coalition of Community Mental Health Centers, testimony on July 24 per transcript pages 61 and 63.
29. Written testimony provided by Jim Moody, Lobbyist for Missouri Coalition of Community Mental Health Centers on July 24.
30. Written testimony provided by James Braibish, Director, External Affairs, American Red Cross St. Louis Area Chapter on July 24.
31. Eric Michael, William M. Mercer, testimony on August 7 per transcript page 131.
32. Samantha Ventimiglia, Policy Analyst for National Governor's Association, testimony on July 19 per transcript pages 30-40.
33. Eric Michael, William M. Mercer, testimony on August 7 per transcript pages 132-140.
34. Ken Anderson, President of Independent Pharmaceutical Consultants Inc., testimony on August 7 per transcript pages 104-117;
35. Lynn Hebenheimer, Division of Medical Services, testimony on August 7 transcript pages 230-232.
36. Eric Michael, William M. Mercer, testimony on August 7 per transcript pages 136-137.
37. Don Muse, Muse and Associates Inc., testimony on August 7 per transcript pages 79-80.

Additional Resources

Appendix A (list of Task Force recommendations)
Appendix B (Adopted Senior Pharmacy Assistance Program Plan Design and Estimated Program Cost)
Appendix C (senior population data)
Appendix D (redistricting information with senior population data)
Appendix E (census data)

Appendix A – Summary of Task Force Recommendations

Phase 1 Recommendations

Recommendation #1 - Repeal $200 pharmacy tax credit and replace with senior pharmacy assistance program that shall have begun enrollment by July 1, 2002. If the senior pharmacy program is not implemented by July 1, 2002, then an alternative tax credit program will be legislated.

Recommendation #2 - Raise Medicaid to 100 percent of the federal poverty level.

Recommendation #3 - Raise Medicaid resource limit to $1,500 and $2,500.

Recommendation #4 - Enrollees pay a percentage of pharmacy cost rather than flat co-pay and the recommended percentage shall be 40 percent of the drug cost.

Recommendation #5 - Coinsurance according to income level and no cap on recipient coinsurance amount. Recommend a cap on state expenditures up to – but not to exceed $5,000 per recipient.

Recommendation #6 – AWP-10.43% for brand name drugs and AWP-20% for generic drugs for ingredient reimbursement and $4.09 dispensing fee to pharmacies.

Recommendation #7 – Incorporate various utilization management initiatives included in the Pharmacy Enhancement Program (PEP) program in the Division of Medical Services in this senior pharmacy program.

Recommendation #8 - Exclude individuals who are receiving Medicaid.

Recommendation #9 - Exclude individuals with adequate third party insurance (those with an actuarial value that is greater than or equal to coverage provided by senior pharmacy program benefit).

Recommendation #10 – Incorporate a 6-month crowd out period and a residency clause to be eligible for the program.

Recommendation #11 - Enrollment fee of $25 for first income tier (up to $12,000 for an individual and $17,000 for a couple) and $35 for the second income tier ($12,001 to $17,000 for an individual and $17,001 to $23,000 for a couple).

Recommendation #12 – Establish an open enrollment period and require that all recipients reenroll every year. In addition, there should be a provision that allows enrollment to be done within 30 days of qualifying events for income changes and age.

Recommendation #13 - Benefit year for program should be July 1 – June 30.

Recommendation #14 - Income levels should be specifically stated in legislation rather than a percentage of the federal poverty level since this will be simpler to participants. First tier of income for program: up to $12,000 for an individual and $17,000 for a couple. Second tier of income for program: $12,001 to $17,000 for an individual and $17,001 to $23,000 for a couple. There should be a "means test" e.g. enrollees should attach copy of last year's income tax statement to their enrollment application for this program to demonstrate they meet the income requirements.

Recommendation #15 – Authorization of administering authority to make future recommendations on plan design.

Recommendation #16 – In the event there was inadequate funding available for the program, then the administering authority could consider funding first tier income eligibles only, in addition to implementing other cost control measures.

Recommendation #17 – The program established should not exceed 200% of the federal poverty level.

Recommendation #18 – Deductible of $250 for first income tier and $500 for second income tier. Further, the administering authority should recommend changing the deductible amounts as one of the cost control measures for the program.

Recommendation #19 – Recommend legislation to require minimum rebates of 15 percent for brand name drugs and 11 percent for generic drugs.

Recommendation #20 – Recommend Department of Health and Senior Services to administer the program and contract out with a third party to administer the senior pharmacy program.

Recommendation #21 – Provide a medical healthcare clearinghouse to educate seniors of pharmacy programs available to them in conjunction with other resources available.

Recommendation #22 – Adopt recommendations made by the task force that will be incorporated in the final report. The final vote shall be Friday, August 31, at 9:00 a.m. Dissenters shall be given the opportunity to attach their opinions to the report.

Phase Two Recommendations

Recommendation #1 – Recommend DMS implement cost containment initiatives provided by Don Muse in his presentation for the Medicaid program at the Joplin hearing.

Recommendation #2 – In the future, the general assemblies should look at expanding the income level of the senior pharmacy assistance program if the monies, including federal funds, should become available.

Recommendation #3 – The General Assembly should further examine increasing provider reimbursement in the Medicaid program to the usual and customary amounts and identify the costs associated with this recommendation.

Recommendation #4 – The General Assembly should examine innovative ways to increase reimbursement to health care providers in rural areas of the state.

Recommendation #5 – In the future, the General Assembly should consider developing a buy-in program for those seniors above the current income eligibility, at an actuarially sound level.

Recommendation #6 – In the future, the General Assembly should consider developing a disease control model similar to the Illinois model.

Appendix B - Adopted Senior Pharmacy Assistance Program

Benefit Design

	Tier 1	Tier 2
Income	<12,000 for an individual <17,000 for a couple	<17,000 for an individual <23,000 for a couple
Enrollment Fee	$25 per year	$35 per year
Deductible	$250	$500
Annual Benefit	$5,000	$5,000
Coinsurance	40%	40%
Eligible Seniors	287,820	94,830
Participants		
FY 03	37,260	13,220
FY 04	57,310	20,330

State Program Cost

State Cost Net of 15% Brand / 11% Generic Rebates	
FY 03	$45 – 52 million
FY 04	$75 – 85 million
Clearinghouse	**$1.7 million** *

* Cost estimate provided by Senator Singleton

Total State Program Cost

FY 03	$46.7 – 53.7 million
FY 04	$76.7 – 86.7 million

Appendix C

MISSOURI HOUSE OF REPRESENATIVE DISTRICT	CENSUS 2000 TOTAL POP.	POP. AGE 65 AND OVER	% Over 65	POP. AGE 60 AND OVER	% AGE 60 AND OVER
State House District 1	31,424	5,627	17.9%	7,179	22.8%
State House District 2	33,333	4,737	14.2%	6,041	18.1%
State House District 3	32,959	6,734	20.4%	8,466	25.7%
State House District 4	30,724	4,910	16.0%	6,124	19.9%
State House District 5	32,982	5,779	17.5%	7,254	22.0%
State House District 6	36,584	4,978	13.6%	6,501	17.8%
State House District 7	31,955	6,437	20.1%	7,879	24.7%
State House District 8	31,325	6,014	19.2%	7,591	24.2%
State House District 9	34,548	5,471	15.8%	7,125	20.6%
State House District 10	31,564	5,303	16.8%	6,554	20.8%
State House District 11	42,429	5,306	12.5%	6,915	16.3%
State House District 12	40,908	4,062	9.9%	5,474	13.4%
State House District 13	47,970	4,144	8.6%	6,003	12.5%
State House District 14	66,841	3,794	5.7%	5,460	8.2%
State House District 15	35,759	3,738	10.5%	5,134	14.4%
State House District 16	39,958	2,875	7.2%	4,136	10.4%
State House District 17	28,984	2,210	7.6%	3,078	10.6%
State House District 18	31,527	4,793	15.2%	6,129	19.4%
State House District 19	36,661	5,277	14.4%	7,073	19.3%
State House District 20	39,359	4,356	11.1%	5,760	14.6%
State House District 21	36,309	5,250	14.5%	6,791	18.7%
State House District 22	32,935	4,756	14.4%	6,040	18.3%
State House District 23	39,376	4,511	11.5%	5,842	14.8%
State House District 24	42,594	2,816	6.6%	4,048	9.5%
State House District 25	33,834	2,243	6.6%	2,849	8.4%
State House District 26	32,711	5,287	16.2%	6,638	20.3%
State House District 27	30,419	4,396	14.5%	5,472	18.0%
State House District 28	35,182	5,525	15.7%	6,980	19.8%
State House District 29	33,275	4,296	12.9%	5,691	17.1%
State House District 30	41,937	2,775	6.6%	4,134	9.9%
State House District 31	32,508	4,144	12.7%	5,399	16.6%
State House District 32	41,656	3,659	8.8%	4,987	12.0%
State House District 33	31,890	5,174	16.2%	6,652	20.9%
State House District 34	38,034	3,885	10.2%	5,280	13.9%
State House District 35	48,141	3,982	8.3%	5,645	11.7%
State House District 36	32,780	4,465	13.6%	5,963	18.2%
State House District 37	27,699	3,586	12.9%	4,458	16.1%
State House District 38	28,237	2,639	9.3%	3,348	11.9%
State House District 39	28,844	3,220	11.2%	4,176	14.5%
State House District 40	33,513	3,412	10.2%	4,392	13.1%
State House District 41	27,291	3,328	12.2%	4,239	15.5%
State House District 42	27,054	3,511	13.0%	4,658	17.2%
State House District 43	27,904	2,947	10.6%	4,097	14.7%
State House District 44	30,224	3,995	13.2%	4,852	16.1%

State House District 45	29,647	5,742	19.4%	6,939	23.4%
State House District 46	32,337	4,291	13.3%	5,736	17.7%
State House District 47	42,743	5,853	13.7%	7,263	17.0%
State House District 48	31,468	3,638	11.6%	4,789	15.2%
State House District 49	31,128	6,205	19.9%	7,626	24.5%
State House District 50	29,567	5,093	17.2%	6,280	21.2%
State House District 51	31,134	4,723	15.2%	5,925	19.0%
State House District 52	33,260	5,549	16.7%	7,391	22.2%
State House District 53	32,795	3,587	10.9%	4,820	14.7%
State House District 54	40,762	3,252	8.0%	4,609	11.3%
State House District 55	44,166	3,345	7.6%	4,715	10.7%
State House District 56	45,107	4,065	9.0%	5,724	12.7%
State House District 57	21,660	3,585	16.6%	4,396	20.3%
State House District 58	22,363	2,515	11.2%	3,184	14.2%
State House District 59	28,301	2,362	8.3%	3,074	10.9%
State House District 60	24,954	4,787	19.2%	5,833	23.4%
State House District 61	24,919	2,972	11.9%	4,007	16.1%
State House District 62	24,107	3,699	15.3%	4,708	19.5%
State House District 63	25,786	2,849	11.0%	3,559	13.8%
State House District 64	27,829	3,482	12.5%	4,496	16.2%
State House District 65	28,523	4,543	15.9%	5,471	19.2%
State House District 66	31,686	4,735	14.9%	5,711	18.0%
State House District 67	31,378	2,660	8.5%	3,426	10.9%
State House District 68	30,278	5,905	19.5%	6,976	23.0%
State House District 69	31,417	2,911	9.3%	3,978	12.7%
State House District 70	27,008	2,807	10.4%	3,775	14.0%
State House District 71	29,144	3,082	10.6%	4,231	14.5%
State House District 72	28,555	3,621	12.7%	4,893	17.1%
State House District 73	32,682	4,907	15.0%	5,902	18.1%
State House District 74	35,164	3,895	11.1%	5,241	14.9%
State House District 75	31,073	4,515	14.5%	5,597	18.0%
State House District 76	29,936	5,477	18.3%	6,603	22.1%
State House District 77	29,869	3,598	12.0%	4,849	16.2%
State House District 78	30,858	4,162	13.5%	5,418	17.6%
State House District 79	24,616	2,781	11.3%	3,758	15.3%
State House District 80	30,656	4,736	15.4%	5,921	19.3%
State House District 81	30,795	4,312	14.0%	5,411	17.6%
State House District 82	31,474	5,997	19.1%	7,632	24.2%
State House District 83	31,460	5,589	17.8%	6,900	21.9%
State House District 84	31,077	2,935	9.4%	3,831	12.3%
State House District 85	31,234	3,368	10.8%	4,847	15.5%
State House District 86	31,869	6,490	20.4%	8,168	25.6%
State House District 87	31,560	5,943	18.8%	7,392	23.4%
State House District 88	35,000	4,141	11.8%	5,626	16.1%
State House District 89	55,018	3,574	6.5%	5,082	9.2%
State House District 90	40,263	2,627	6.5%	3,768	9.4%
State House District 91	32,585	5,913	18.1%	6,991	21.5%
State House District 92	32,701	3,469	10.6%	4,841	14.8%
State House District 93	34,629	3,390	9.8%	4,786	13.8%

State House District 94	29,991	5,694	19.0%	6,843	22.8%
State House District 95	33,244	5,906	17.8%	7,435	22.4%
State House District 96	30,286	5,862	19.4%	7,140	23.6%
State House District 97	35,601	5,325	15.0%	7,119	20.0%
State House District 98	30,556	6,318	20.7%	7,621	24.9%
State House District 99	31,532	7,368	23.4%	9,121	28.9%
State House District 100	34,239	3,467	10.1%	4,798	14.0%
State House District 101	37,881	3,049	8.0%	4,409	11.6%
State House District 102	35,873	2,670	7.4%	3,973	11.1%
State House District 103	35,422	4,558	12.9%	6,076	17.2%
State House District 104	36,352	3,954	10.9%	5,431	14.9%
State House District 105	34,890	2,788	8.0%	4,068	11.7%
State House District 106	36,645	6,042	16.5%	7,711	21.0%
State House District 107	34,605	4,855	14.0%	6,527	18.9%
State House District 108	29,560	4,471	15.1%	5,447	18.4%
State House District 109	36,287	4,402	12.1%	5,807	16.0%
State House District 110	36,432	4,117	11.3%	5,665	15.5%
State House District 111	34,994	4,925	14.1%	6,571	18.8%
State House District 112	33,951	5,658	16.7%	7,353	21.7%
State House District 113	34,995	3,379	9.7%	4,510	12.9%
State House District 114	36,402	4,702	12.9%	6,008	16.5%
State House District 115	36,630	6,272	17.1%	8,506	23.2%
State House District 116	40,169	7,696	19.2%	10,658	26.5%
State House District 117	35,740	5,181	14.5%	6,616	18.5%
State House District 118	34,411	5,458	15.9%	6,832	19.9%
State House District 119	37,745	8,217	21.8%	10,971	29.1%
State House District 120	34,173	5,791	16.9%	7,538	22.1%
State House District 121	33,826	2,733	8.1%	3,628	10.7%
State House District 122	32,960	5,079	15.4%	6,566	19.9%
State House District 123	41,271	4,848	11.7%	6,402	15.5%
State House District 124	40,541	4,653	11.5%	6,372	15.7%
State House District 125	33,821	5,678	16.8%	7,173	21.2%
State House District 126	34,887	5,680	16.3%	7,077	20.3%
State House District 127	37,550	4,235	11.3%	5,823	15.5%
State House District 128	36,806	5,284	14.4%	6,663	18.1%
State House District 129	35,114	5,108	14.5%	6,647	18.9%
State House District 130	36,949	4,950	13.4%	6,534	17.7%
State House District 131	37,039	5,064	13.7%	6,847	18.5%
State House District 132	36,330	5,514	15.2%	7,124	19.6%
State House District 133	34,945	6,439	18.4%	8,368	23.9%
State House District 134	43,044	5,530	12.8%	7,218	16.8%
State House District 135	39,218	7,079	18.1%	8,956	22.8%
State House District 136	38,995	5,426	13.9%	6,658	17.1%
State House District 137	33,041	3,354	10.2%	4,326	13.1%
State House District 138	30,875	3,914	12.7%	4,921	15.9%
State House District 139	35,322	4,960	14.0%	6,497	18.4%
State House District 140	39,321	4,541	11.5%	6,278	16.0%
State House District 141	45,789	8,612	18.8%	11,996	26.2%
State House District 142	51,623	5,517	10.7%	7,358	14.3%

State House District 143	44,638	7,011	15.7%	9,502	21.3%
State House District 144	33,314	5,574	16.7%	7,344	22.0%
State House District 145	37,593	5,771	15.4%	7,393	19.7%
State House District 146	37,573	5,326	14.2%	7,109	18.9%
State House District 147	30,441	4,157	13.7%	5,450	17.9%
State House District 148	33,727	3,206	9.5%	4,350	12.9%
State House District 149	34,970	4,893	14.0%	6,359	18.2%
State House District 150	35,556	5,730	16.1%	7,605	21.4%
State House District 151	37,238	6,248	16.8%	8,136	21.8%
State House District 152	31,918	4,665	14.6%	6,272	19.7%
State House District 153	33,260	5,693	17.1%	7,587	22.8%
State House District 154	31,778	5,709	18.0%	7,293	22.9%
State House District 155	33,621	5,200	15.5%	6,641	19.8%
State House District 156	35,708	5,825	16.3%	7,898	22.1%
State House District 157	40,750	5,153	12.6%	6,778	16.6%
State House District 158	29,291	4,446	15.2%	5,477	18.7%
State House District 159	33,524	5,713	17.0%	7,350	21.9%
State House District 160	31,958	4,412	13.8%	5,828	18.2%
State House District 161	30,514	4,491	14.7%	5,869	19.2%
State House District 162	29,177	4,629	15.9%	5,904	20.2%
State House District 163	32,107	5,180	16.1%	6,767	21.1%
STATE TOTALS	**5,595,211**	**755,379**	**13.5%**	**983,704**	**17.6%**

Appendix D

MISSOURI SENATE DISTRICT	CENSUS 2000 TOTAL POP.	POP. AGE 65 AND OVER	% AGE 65 AND OVER	POP. AGE 60 AND OVER	% AGE 60 AND OVER
State Senate District 1	156,438	28,016	17.9%	35,541	22.7%
State Senate District 2	186,370	20,668	11.1%	27,887	15.0%
State Senate District 3	148,048	24,172	16.3%	29,109	19.7%
State Senate District 4	123,913	17,573	14.2%	22,062	17.8%
State Senate District 5	120,255	14,009	11.6%	17,785	14.8%
State Senate District 6	171,887	26,219	15.3%	34,278	19.9%
State Senate District 7	151,186	22,817	15.1%	30,350	20.1%
State Senate District 8	192,841	20,937	10.9%	28,010	14.5%
State Senate District 9	136,275	19,095	14.0%	24,576	18.0%
State Senate District 10	146,559	22,081	15.1%	27,736	18.9%
State Senate District 11	149,481	16,950	11.3%	21,775	14.6%
State Senate District 12	155,606	28,236	18.1%	35,416	22.8%
State Senate District 13	134,740	14,251	10.6%	19,325	14.3%
State Senate District 14	151,551	21,681	14.3%	27,280	18.0%
State Senate District 15	156,923	20,893	13.3%	26,554	16.9%
State Senate District 16	178,632	26,560	14.9%	34,816	19.5%
State Senate District 17	184,006	19,848	10.8%	26,605	14.5%
State Senate District 18	152,041	25,100	16.5%	31,756	20.9%
State Senate District 19	170,329	16,948	10.0%	22,295	13.1%
State Senate District 20	159,986	23,997	15.0%	31,780	19.9%
State Senate District 21	166,604	24,338	14.6%	31,394	18.8%
State Senate District 22	167,100	14,418	8.6%	20,597	12.3%
State Senate District 23	191,469	16,401	8.6%	22,709	11.9%
State Senate District 24	143,002	22,170	15.5%	27,715	19.4%
State Senate District 25	156,793	26,058	16.6%	33,891	21.6%
State Senate District 26	195,599	19,587	10.0%	26,771	13.7%
State Senate District 27	164,503	23,880	14.5%	30,747	18.7%
State Senate District 28	190,010	27,765	14.6%	36,118	19.0%
State Senate District 29	216,520	33,424	15.4%	44,987	20.8%
State Senate District 30	167,228	24,393	14.6%	30,665	18.3%
State Senate District 31	178,652	23,100	12.9%	30,523	17.1%
State Senate District 32	179,003	24,258	13.6%	31,736	17.7%
State Senate District 33	175,390	23,773	13.6%	32,415	18.5%
State Senate District 34	176,271	21,763	12.3%	28,500	16.2%
STATE TOTALS	**5,595,211**	**755,379**	**13.5%**	**983,704**	**17.6%**

Appendix E

STATE	Census 2000 total pop. (all ages)	Census 2000 total pop. age 65+	Age 65+ as percent of pop. in 2000	1990 Total pop. (all ages)	1990 Census total pop. age 65+	Age 65+ as percent of pop. in 1990	1990-2000 pop. change age 65+	% change 1990-2000 age 65+
Alabama	4,447,100	579,798	13.0%	4,040,587	522,989	12.9%	56,809	10.9%
Alaska	626,932	35,699	5.7%	550,043	22,369	4.1%	13,330	59.6%
Arizona	5,130,632	667,839	13.0%	3,665,228	478,774	13.1%	189,065	39.5%
Arkansas	2,673,400	374,019	14.0%	2,350,725	350,058	14.9%	23,961	6.8%
California	33,871,648	3,595,658	10.6%	29,760,021	3,135,552	10.5%	460,106	14.7%
Colorado	4,301,261	416,073	9.7%	3,294,394	329,443	10.0%	86,630	26.3%
Connecticut	3,405,565	470,183	13.8%	3,287,116	445,907	13.6%	24,276	5.4%
Delaware	783,600	101,726	13.0%	666,168	80,735	12.1%	20,991	26.0%
District of Columbia	572,059	69,898	12.2%	606,900	77,847	12.8%	-7,949	-10.2%
Florida	15,982,378	2,807,597	17.6%	12,937,926	2,369,431	18.3%	438,166	18.5%
Georgia	8,186,453	785,275	9.6%	6,478,216	654,270	10.1%	131,005	20.0%
Hawaii	1,211,537	160,601	13.3%	1,108,229	125,005	11.3%	35,596	28.5%
Idaho	1,293,953	145,916	11.3%	1,006,749	121,265	12.0%	24,651	20.3%
Illinois	12,419,293	1,500,025	12.1%	11,430,602	1,436,545	12.6%	63,480	4.4%
Indiana	6,080,485	752,831	12.4%	5,544,159	696,196	12.6%	56,635	8.1%
Iowa	2,926,324	436,213	14.9%	2,776,755	426,106	15.3%	10,107	2.4%
Kansas	2,688,418	356,229	13.3%	2,477,574	342,571	13.8%	13,658	4.0%
Kentucky	4,041,769	504,793	12.5%	3,685,296	466,845	12.7%	37,948	8.1%
Louisiana	4,468,976	516,929	11.6%	4,219,973	468,991	11.1%	47,938	10.2%
Maine	1,274,923	183,402	14.4%	1,227,928	163,373	13.3%	20,029	12.3%
Maryland	5,296,486	599,307	11.3%	4,781,468	517,482	10.8%	81,825	15.8%
Massachusetts	6,349,097	860,162	13.5%	6,016,425	819,284	13.6%	40,878	5.0%
Michigan	9,938,444	1,219,018	12.3%	9,295,297	1,108,461	11.9%	110,557	10.0%
Minnesota	4,919,479	594,266	12.1%	4,375,099	546,934	12.5%	47,332	8.7%
Mississippi	2,844,658	343,523	12.1%	2,573,216	321,284	12.5%	22,239	6.9%
Missouri	5,595,211	755,379	13.5%	5,117,073	717,681	14.0%	37,698	5.3%
Montana	902,195	120,949	13.4%	799,065	106,497	13.3%	14,452	13.6%
Nebraska	1,711,263	232,195	13.6%	1,578,385	223,068	14.1%	9,127	4.1%
Nevada	1,998,257	218,929	11.0%	1,201,833	127,631	10.6%	91,298	71.5%
New Hampshire	1,235,786	147,970	12.0%	1,109,252	125,029	11.3%	22,941	18.3%
New Jersey	8,414,350	1,113,136	13.2%	7,730,188	1,032,025	13.4%	81,111	7.9%
New Mexico	1,819,046	212,225	11.7%	1,515,069	163,062	10.8%	49,163	30.1%
New York	18,976,457	2,448,352	12.9%	17,990,455	2,363,722	13.1%	84,630	3.6%
North Carolina	8,049,313	969,048	12.0%	6,628,637	804,341	12.1%	164,707	20.5%
North Dakota	642,200	94,478	14.7%	638,800	91,055	14.3%	3,423	3.8%
Ohio	11,353,140	1,507,757	13.3%	10,847,115	1,406,961	13.0%	100,796	7.2%
Oklahoma	3,450,654	455,950	13.2%	3,145,585	424,213	13.5%	31,737	7.5%
Oregon	3,421,399	438,177	12.8%	2,842,321	391,324	13.8%	46,853	12.0%

Pennsylvania	12,281,054	**1,919,165**	**15.6%**	11,881,643	**1,829,106**	**15.4%**	**90,059**	**4.9%**
Rhode Island	1,048,319	**152,402**	**14.5%**	1,003,464	**150,547**	**15.0%**	**1,855**	**1.2%**
South Carolina	4,012,012	**485,333**	**12.1%**	3,486,703	**396,935**	**11.4%**	**88,398**	**22.3%**
South Dakota	754,844	**108,131**	**14.3%**	696,004	**102,331**	**14.7%**	**5,800**	**5.7%**
Tennessee	5,689,283	**703,311**	**12.4%**	4,877,185	**618,818**	**12.7%**	**84,493**	**13.7%**
Texas	20,851,820	**2,072,532**	**9.9%**	16,986,510	**1,716,576**	**10.1%**	**355,956**	**20.7%**
Utah	2,233,169	**190,222**	**8.5%**	1,722,850	**149,958**	**8.7%**	**40,264**	**26.9%**
Vermont	608,827	**77,510**	**12.7%**	562,758	**66,163**	**11.8%**	**11,347**	**17.2%**
Virginia	7,078,515	**792,333**	**11.2%**	6,187,358	**664,470**	**10.7%**	**127,863**	**19.2%**
Washington	5,894,121	**662,148**	**11.2%**	4,866,692	**575,288**	**11.8%**	**86,860**	**15.1%**
West Virginia	1,808,344	**276,895**	**15.3%**	1,793,477	**268,897**	**15.0%**	**7,998**	**3.0%**
Wisconsin	5,363,675	**702,553**	**13.1%**	4,891,769	**651,221**	**13.3%**	**51,332**	**7.9%**
Wyoming	493,782	**57,693**	**11.7%**	453,588	**47,195**	**10.4%**	**10,498**	**22.2%**
U.S. TOTAL	**281,421,906**	**34,991,753**	**12.4%**	**248,709,873**	**31,241,831**	**12.6%**	**3,749,922**	**12.0%**

Appendix F

Written Testimony for Lt. Governor Joe Maxwell on Prescription Drugs for the Elderly

August 29, 2001

Steven Zweig, MD, MSPH
Professor and Associate Chair
Department of Family and Community Medicine
University of Missouri-Columbia, School of Medicine

FACTS

1. Medicare is a health insurance program available to virtually every US senior.
   - -Part A is free and covers hospital care, limited skilled nursing stays, and specific home health services.
   - -Part B costs $45.50/month and covers professional services with accompanying copays and deductible charges.

2. Medicare does not cover outpatient prescription and over the counter drugs. Privately purchased Medigap policies are expensive costing up to an additional thousands of dollars per year with an annual $250 deductible, 50% copayment, and an annual benefit cap of $1250 or $3000.

3. Spending on prescription drugs is increasing at a rate far exceeding professional and hospital spending. Between 1990 and 1998, hospital and physician spending increased 57% and 50% respectively and prescription drug spending increased 140% (Health Care Financing Administration data quoted in *USA Today*, 9/28/2000).

4. The 25 most heavily promoted drugs accounted for 40% of the increase in retail drug spending in 1999. Physicians are much more likely to prescribe these heavily promoted drugs (34% more vs. 5% more for all other drugs) (National Institute for Health Care Management data quoted in *USA Today*, 9/28/2000).

5. 86% of Medicare beneficiaries filled at least one prescription in 1995 (*Health Care Financing Review* 1999[Spring]:15-27). Each person fills an average of 18 prescriptions/year. While the average total cost is $1343, the average person with coronary artery disease, high cholesterol, and Type 2 diabetes spends over $3000/year (*Health Affairs* 2000;19:198-211).

6. 65% of Medicare beneficiaries (those not in nursing homes) have some form of insurance coverage for prescription drugs. Of those with coverage:
   - 60% have supplemental plans
   - 47% are employer sponsored
   - 13% are privately purchased Medigap policies
   - 20% are members of Medicare HMOs
   - 20% are covered by public programs
   - Medicaid 17%
   - Other – VA, Department of Defense, state assistance 3%
   - (*Health Affairs* 1999 [Jan-Feb]:213-243)

7. Those without coverage are more likely to have lower incomes (<200% poverty), to be of fair or poor health status, and to be older than 75 years (AARP PPI analysis using Medicare Benefits Simulation Model 1999).

8. Out of pocket spending is greater for those without coverage (mean $590 vs. $320/year). [*A Medicare Prescription Drug Benefit*, Medicare Brief #1, National Academy of Social Insurance, April 1999]. Those with privately purchased Medigap policies have the highest out of pocket costs (mean $570/year). Even those with Medicaid for a portion of the year or QMB supplement have high out of

pocket costs ($380 and $205/year). Those with employer-sponsored plans have high costs ($320/year), but they also have the highest total drug spending.

9. Employer sponsored plans are declining, 35% of seniors in 1995, only 30% in 1998 (*Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 1998: Report of Survey Findings*, p.38).

10. Medigap policies may only be available to those enrolled less than 6 months in Medicare. High prescription drugs users are more likely to disenroll from Medicare HMOs and may not then qualify for their former Medigap plans leaving them with no insurance for prescription drugs (*JAMA* 2000;283:2163-2167).

11. Many poor people do not receive Medicaid benefits. In 1999, an estimated 45% of noninstitutionalized Medicare beneficiaries with incomes below the federal poverty level received no Medicaid assistance (*Issue Brief* no. 39, AARP).

IMPERFECT SOLUTIONS

1. Indigent Drug Programs

I care for an 81-year-old retired journalist who by virtue of a good break on his rent lives in a small apartment at Tiger Columns in Columbia. He has Parkinson's disease and is increasingly frail. He cannot afford prescription drug coverage and does not qualify for Medicaid. We have arranged to get his Sinemet (a medication to treat Parkinson's disease) from the maker through an indigent drug program. After substantial initial paperwork, every 3 months, we reenroll him in this plan and they send the drugs to me, which I give to him. This past week I received a letter from the company telling me this drug would no longer be available under the plan. While my patients and I appreciate these programs they have several problems:

- Each company has a different application process, requesting different information, and different income levels to qualify.
- Most chronically ill elderly take more than one drug.
- Physicians and patients may not know about these plans or do the work required to apply for them.
- Only drugs without generic alternative are usually available.
- The time delay between application (or renewal of prescription) and receiving the drugs can lead to weeks to months without medications.
- Plans can be terminated at any time.

At University Hospital, we pay social workers to help patients enroll in these plans and to get needed medications. This is a very time consuming process and is not reimbursed. (The best website for such information with phone numbers, addresses and eligibility information for drug companies producing over 900 medications is: www.needymeds.com)

My patient may soon be faced with paying his rent or getting his life-saving medications. Without his medications he will literally freeze-up due to his disease, he will fall, and may suffer serious injury. His only solution may be to enter a nursing home, soon qualify for Medicaid and thereby receive his medications, but at a substantial cost to the Medicaid program (over $3000/month).

2. Cobbled together plans – discontinuity and injury

My 83-year-old father in law, who recently died, had congestive heart failure, coronary artery disease, type 2 diabetes, and treated prostate cancer – fulfilling many of the characteristics of a typical World War II veteran. He had a good doctor in this city and supplemental insurance of a retired state employee that did not cover prescription drugs. While he did not qualify for full VA health benefits because his income was too great, he made periodic visits to a VA physician to get some of his prescriptions filled. After weeks of abdominal pain and weight loss, we discovered that his VA doctor had put him on an arthritis drug that his regular doctor did not know about. This drug had caused an ulcer. This discontinuity of care precipitated by efforts to get discounted prescriptions caused significant injury that could have been life threatening.

3. Use of drug samples

In my role as medical director of a multidisciplinary geriatric assessment clinic at the University (SAGE clinic), I frequently encounter patients who have been given drug samples for chronic health problems by their well-intended physicians. Unfortunately the only samples provided by drug companies are expensive, newly marketed drugs. While the first week or month of the drug may be free, the patient is now committed to an expensive drug, which may be far less affordable than a much less expensive alternative not available as a sample.

4. The Medicaid "spend-down" problem

Changes in state regulations made it impossible for Medicaid recipients to receive more than 31 days of medications from the pharmacy. This meant that many people who reached their spend down by purchasing 3 months of medications at one time, could no longer qualify for Medicaid – and therefore, were not be able to afford to get all or even a portion of their prescribed drugs. This regulation was changed, but it points to the significance of the Medicaid program and its regulations regarding prescription drugs for poor seniors.

Summary

By 2020, 20% of the US population will be 65+ years. The 85+ group is the fastest growing portion of our population. Older people are taking more prescription drugs and these drugs are increasingly expensive. This is true in part because of the higher cost of many new drugs, some of which have been very helpful in treating the chronic diseases accumulated by many older people. Medicare is an incomplete insurance program that does not cover these or many other costs of health care. While the majority of Medicare recipients have some form of insurance for prescription drugs, this insurance is not adequate to cover the costs of most Medicare beneficiaries. It is difficult for even a very poor elderly person to qualify for Medicaid, unless they have become a pauper through a long-term nursing home stay (it takes an average of just 7 months in the nursing home to qualify for Medicaid). Unfortunately, the absence of needed drugs may precipitate institutionalization due to loss of function.

Expectations for medical care increase each year in the US. It is clear that additional pharmaceutical benefits will expand the use of prescription drugs. As physicians, we should make sure that our patients are only taking medications that will show demonstrated benefits for our patients. Physicians must be familiar with drug costs and the least expensive good alternatives. They also need to engage patients in the decision making process of taking these medications or not. As a wealthy society, which fuels these high expectations for health and health care, we must address particularly the care of those most in need.

Appendix G

Witness List for the Governor's Task Force on Prescription Drugs for Seniors

Jefferson City Hearing, July 19, 2001
Governor Bob Holden
Kathy Martin, Director of Department of Social Services
Denise Cross, Director of Division of Family Services
Samantha Ventimiglia, Policy Analyst, National Governor's Association
Pam Victor, Deputy Director of the Division of Medical Services
Ron Meyer, Executive Director of the MO Consolidated Health Care Plan
Scott Lakin, Director of the Department of Insurance

St. Louis Hearing, July 24, 2001
Jeanne Piffel
Ray Davidson, Older Adult Community Action Program
Joel Corman
Governor Bob Holden
Fran Buyatte
Betty Simmens
Maurissa Johnson
Jim Moody, MO Coalition of Community Health Centers
Diane McFarland, BJC Behavioral Health Services/MO Coalition of Community Mental health Centers
Fran Scott, Mental Health Consumers on Disability of MO
Dr. Robert Hill, Director of Medical Education at Forest Park Hospital
George Oestreich, MP Pharmacy Association
Paul Pernishero, R.Ph
Mayor Francis Slay
Kim Carmichael, M.D.
Brian Long, Director of Budget and Planning
Carroll Rodriguez, Alzheimer's Association
Dr. Charles Crecelius, President of MO Association of Long Term Care Physicians and Board Member of the American Medical Association
Dr. Stephanie Van Ulft, Psychiatrist at St. Alexius
Ann Steele, OWL
Nancy McCollogh
Marie Nowak, Silver Haired Legislature
Jim Braibish, American Red Cross, St. Louis Chapter
Toni Vafi, Missouians for Single Payer Universal Insurance
Representative Mike Reid
Albert Prentiss
Ronald Levy, Silver Haired Legislature
Marie Garfield
Dorothy Jenkins
Henry Hampel
National Association of Mentally Ill
Marge Parrish

Joplin Hearing, August 7, 2001
Francis Radtke, Area Agency on Aging
Betty Kowalewick, Silver Haired Legislature
Don Hall, Silver Hired Legislature
Susan Alden, Division of Aging
Jo Schiner
Charles McManus
Frank Compton
Representative Gary Burton
Speaker Jim Kreider

Representative Mark Abel
Ben Johnson
Don Muse, Muse and Associates
Ken Anderson, President of Independent Pharmaceutical Consultants Inc.
Eric Michael, William Mercer, Inc
Senator Mathewson
Ron Meyer, Executive Director of the MO Consolidated Health Care Plan
Lynn Hebenheimer, Division of Medical Services
Carol Fisher, Director of the MO Department of Revenue
Mr. Penner

Kansas City Hearing, August 17, 2001
Keith Hardin
Kay Cresson
Mike Khiz
Kathleen Morrow
Lillie Campbell
Mary Troger
William Ferleman
Lenore Lynn
Betty Gilpin
Louise Monaco
Josephine Palazzo
Thomas Snedden
Norma Collins
Frearioka Larnoff
Daniel Gumpert
Anna Badomi
Cheryl Dillard
Mike Staudenmauer
Margie Peltier
June Darnell
Wanda Jenkins
Vanessa Allen

Columbia Hearing, August 28, 2001
Rep. Tim Harlan on behalf of former Rep. Paul Sonnbar
Rep. Riback Wilson
Ruth Branden
Cindi Keele
Bob Whittet
Pat Murdock
Shawn Spradling
Steve Adams
Wayne Vaughn